North Shore-LIJ Health System

Visiting House Staff and Medical Student Medical Clearance Form Instructions

Health Assessment

*Visiting House Staff and Medical Student Clearance Form which must be completed and signed by your health care provider. Practitioner must put title and stamp on form*

Tuberculosis Screening

Option 1: Provide date and result of (1) Tuberculin Skin Tests within 12 months of rotation on licensed practitioner’s or hospital Employee Health Service letterhead.

-OR-

Option 2: Provide documentation from Blood based Tuberculosis Screen Tests within 12 months of rotation. Approved FDA test are: QuantiFERON-TB Gold; QuantiFERON-TB Gold In-Tube; TSpot.TB.

If TST or Blood Based Tuberculosis screening results is positive, then submit chest x-ray report performed within 12 months of rotation documenting no active disease.

Proof of Immunity via blood titers OR vaccination records

Titers:
- All titers must be official lab reports.
- The name and address of the lab must be on the lab results.

Vaccination Records must include the following:
- Name of Product (Vaccine)
- Date the vaccination was administered
- Contact information of the vaccinator or facility (i.e.; Office Stamp)

Requirements for Medical Clearance:
- Rubella lab report OR documentation of one (1) MMR immunization
- Rubeola lab report OR documentation of two (2) MMR immunizations
- Mumps lab report OR documentation of two (2) MMR immunizations
- Varicella lab report OR documentation of two (2) Varicella immunization OR documented dates of disease signed by the practitioner
- Hepatitis B Surface Antibody Titer lab report OR documentation of the initiated Hepatitis B vaccination series OR declined vaccination series

Other Requirements:

Tdap/DTaP – Tetanus, Diphtheria and Pertussis Vaccination
Influenza - (Flu) Vaccination during Influenza season which is determined by New York State Department of Health Commissioner (as of July 2013 forward).

Vaccine documentation must include the Name of the Vaccine, the date the vaccine was administered, Contact information of the vaccinator or facility.

Instructions for submission:
- Once you have uploaded the above requirements as a supplemental document in VSAS, **YOU MUST** send an email to qualityrn@nshs.edu with notification of the upload. No documents will be accepted via email or fax
- Please be sure to include: VSAS/ your name/ your rotation date in the subject area
- You must send the email every time you upload new documentation. **No documents will be accepted via email or fax**
Employee Health Services Medical Clearance
Visiting Student Application Service (VSAS)

Failure to complete this form and submit it at least 30 working days prior to the date of the rotation may delay the commencement of your start date.

Name: ___________________________________________ DOB: ____ / ____ / ____

[ ] Male  [ ] Female  Telephone: ( ) __________________________ Email: ______________________________________________________

Current Hospital/School: __________________________________________________________

North Shore-LIJ Health System Rotation Information

NS-LIJ Rotation Location: __________________________________________ Department: __________________________

Rotation Start: ____ / ____ / ____  Rotation End: ____ / ____ / ____

TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR FACILITY

Tuberculosis (TB) Screening:
Tuberculosis Skin Testing (TST/PPD) or Blood Assay

TB screening must be within the past 12 months or check the positive box below if the individual has a history of a positive tuberculin skin test.

[ ] Negative – Date completed: ____ / ____ / ____  [ ] Positive  Complete Positive TST/PPD Section Below

OR Blood Assay (within 12 months): Date completed: ____ / ____ / ____ Results: [ ] Negative  [ ] Positive

Positive TST/PPD: If you have a history of a positive TST/PPD, complete the chest x-ray and signs and symptoms section below.

You must have had a chest x-ray with no active disease.

Chest X-Ray Date: ____ / ____ / ____ Result: [ ] No Active Disease  TB Treatment given: Date(s): __________________________

Other ______________________________________________________

Tuberculosis Signs and Symptoms Evaluation within the last 12 months

Date of Review: ____ / ____ / ____  Results: [ ] Negative  [ ] Positive

<table>
<thead>
<tr>
<th>Vaccination History</th>
<th>Vaccine #1 Date</th>
<th>Vaccine #2 Date</th>
<th>Lab Reports Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR Vaccine Two doses of MMR</td>
<td>____ / ____ / ____</td>
<td>____ / ____ / ____</td>
<td>[ ]</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles (Rubeola): Two immunizations</td>
<td>____ / ____ / ____</td>
<td>____ / ____ / ____</td>
<td>[ ]</td>
</tr>
<tr>
<td>Mumps: Two immunizations</td>
<td>____ / ____ / ____</td>
<td>____ / ____ / ____</td>
<td>[ ]</td>
</tr>
<tr>
<td>Rubella: (German Measles) One immunation</td>
<td>____ / ____ / ____</td>
<td></td>
<td>[ ]</td>
</tr>
<tr>
<td>Varicella: Two immunizations</td>
<td>____ / ____ / ____</td>
<td>____ / ____ / ____</td>
<td>[ ]</td>
</tr>
<tr>
<td>Tdap/DTaP: Pertussis containing vaccine within last 10 years</td>
<td>____ / ____ / ____</td>
<td></td>
<td>[ ]</td>
</tr>
<tr>
<td>Influenza: Vaccinated within the current flu season.</td>
<td>____ / ____ / ____</td>
<td></td>
<td>[ ]</td>
</tr>
<tr>
<td>Hepatitis B: Complete Hepatitis B Section for individuals that have Direct Patient Care Contact.</td>
<td>[ ] Immune (Lab Reports Attached)</td>
<td>[ ] Declined Vaccination or Initiated Series</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Health Assessment: The above individual has been evaluated in the past 12 months. The results of our evaluation is of sufficient scope to ensure the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, other drugs or substances which may alter the individuals behavior. The office that is completing this form will be responsible for maintaining updated records for the duration of participant’s and/or faculty’s interactions within North Shore-LIJ Health System facilities and provide appropriate supporting documentation upon request.

Health Care Provider or Facility: __________________________ Phone: __________________________

(Please Print) (School designee if applicable)

Health Care Provider or Facility Signature: __________________________ Date: __________________________

Provider/Facility Stamp with Address and Telephone Number:

OFFICE STAMP
Updated May 2015